DOC-25-NS-MED
REV 10/03

CLINICAL NURSING NOTES

Full Name of Cl[illegible]: Young Val[illegible] Consecutive Number: Living Unit:

YEAR / DATE	HOUR AM	HOUR PM	NURSING OBSERVATION — Entries must be legible and written in black ink. Sign full name and title after each entry. record vital signs at beginning of note, as necessary.	SIGNATURE — Sign full name and title after entry.
03/16/05			6p Med round. BP—138/86, P-78. Alert, [illegible]	
			[illegible] med [illegible], pt resting on her bed; [illegible] report	
			[illegible] pt had unsteady gait [illegible]	
			BP—142/67, P-92. Not in any distress. To be seen	[illegible]
			by MD in AM.	
3/17/05			6Pm Reported client sat on floor, [illegible]	
			[illegible] given, no injury noted. client soon fell asleep	
			VS P64 R18 B/P 105/[illegible] Client [illegible], but	
			sleeping. Reported by [illegible] client [illegible]	
			unsteady gait [illegible]	
			[illegible] to follow — up — — —	[illegible]
3/17/05		10p	Fleet enema given as ordered by MD. Check on	
			bed, observed resting & breathing. V/S BP 112/68	
			P68 R18 at 9pm. Continue observation	[illegible]
3/17/05		11pm	At 9pm, she return the enema with medium B/M.	
			As of now she was awake, walking up & down the	
			[illegible] without any distress. Continue [illegible]	[illegible]
03-18-05		[illegible]	Up for the entire night, refused to stay in bed	
			[illegible] out to bed several times AM	
			medication taken [illegible]	[illegible] RN
03-19-05		3p	Is up & around the unit. Meals & medication	
			accepted readily. No complaints offered	[illegible] RN
3/[illegible]/05		[illegible]	[illegible]	[illegible]
03/20/05			6pm T-98.1 [illegible] given for cold. Not in	[illegible]
			any distress.	
03-2[illegible]-05		[illegible]	[illegible]	
			[illegible]	
			[illegible] Did not sleep for the entire night	[illegible] RN

BDC-25-NS-MED
REV 10/03

CLINICAL NURSING NOTES

Full Name of Client: Young Valerie

Consecutive Number:

Living Unit: 314

YEAR / DATE	HOUR AM	HOUR PM	NURSING OBSERVATION — Entries must be legible and written in black ink. Sign full name and title after each entry. record vital signs at beginning of note, as necessary.	SIGNATURE — Sign full name and title after entry.
03/23/05			6:40p Sudafed in progress for cold. T- 98.6 (R)	V. [illegible]
			not in any distress. Fleet enema given	
			8pm reported had large BM	V. [illegible]
3/23/05			Client seen for cold symptoms. VS T 98 P [illegible] R 18	[illegible]
			continue on Sudafed & Tylenol 650.	
03/23/05			Tylenol + Sudafed given for cold. T — 97.6	V. [illegible]
			Not in any distress	
3/24/05	3pm		Temp 98.6 Cold meds in progress. No distress noted	[illegible]
03/24/05			9pm Fleet enema given with good effect had large BM	V. [illegible]
3/27/05			When giving 7 AM med staff c/o that Valerie has an unsteady gait. BP 150/90 P 75 R/18 was sitting in	
			chair. Please have MD evaluate	[illegible]owell
3/27/05			Dr Mehta is aware of Client's unsteady gait.	
			After she takes medication Client in no distress.	
			No anxiety noted. walking about 11Am. no unsteady gait	
			noted. Dr. [illegible] informed will visit client on	[illegible]
			rounds.	
03/28/05			Slept throughout the night. Abdomen is distended	
			AM medication given with some difficulty.	
3/28/05	9A		[illegible] Metas ordered Fleet [illegible] given	
			Robitussin DM given [illegible] to check temp BID [illegible] fluids	[illegible]
03/28/05			Fleet enema given. Robitussin in progress. Black	V. [illegible]
			[illegible] x day. Afebrile — T 98.8 (R)	
3/29/05		8P	A/B therapy continued as ordered. Meds taken	[illegible] RN
			Well. Walking around. No problem noted.	[illegible] RN
3/30/05		8P	Temp 98.0. Pulse 70. R 18. A/B therapy continued.	
3/31/05		8P	Appears comfortable. Diet/meds taken well. No other problem noted.	[illegible] RN

3DC-25-NS-MED
REV 10/03

CLINICAL NURSING NOTES

Full Name of Client: V. Young

Consecutive Number:

Living Unit:

YEAR / DATE	HOUR AM	HOUR PM	NURSING OBSERVATION — Entries must be legible and written in black ink. Sign full name and title after each entry, record vital signs at beginning of note, as necessary.	SIGNATURE — Sign full name and title after entry.
3/29/05	7A		Temp 98.6. Extra fluid given. Cold medication in progress. Observation ongoing. She did not sleep all night.	[illegible]
4/3/05	7A		Consumer did not sleep during the night.	[illegible]
04/03/05		8/p	Fleet enema given with good effect — had large soft BM.	[illegible]
04-05-05	7		Consumer was very disruptive during the night. Tore up toys & hit [illegible]. Sustained a small laceration of lt eye brow. Area cleansed aseptically. IR completed. MD please see.	W Layne RN
4/5/05			[illegible] lt eye brow [illegible] sq MD. Cleansed. Steri-strip applied. Obs.	[illegible]
04-07-05	7A		Rec'd stat consumer fell & sustained injury to lt eye. On examination small abrasion over lt eye brow. Area cleansed aseptically. MD please see.	W Layne RN
4/7/05			[illegible] abrasion lt eye brow seen by MD. Area cleansed. [illegible] oint applied. Obs.	[illegible]
4/11/05	11A		[illegible]	[illegible]
			PMHS 4/11-4/16/05	
4/11/05			[illegible] 4/11/05 9:30 AM went to program & tripped. [illegible] MD to see	[illegible]
4/12/05		6PM	Debrox ear drops in progress. Diet/meds taken well. Appears comfortable.	[illegible] RN
4/13/05		3p	Zyprexa [illegible] BID changed to Zyprexa AM+HS	[illegible]
4/13/05		6PM	Zyprexa dose change was noted and given accordingly. Fleet enema was given. Had large BM. Stomach slightly less distended. Appears comfortable.	[illegible]

BOC-25-NS M
REV 10/[illegible]

CLINICAL NURSING NOTES

Full Name of Client: Young V

Consecutive Number:

Living Unit: 31

YEAR / DATE	HOUR AM	HOUR PM	NURSING OBSERVATION — Entries must be legible and written in black ink. Sign full name and title after each entry. record vital signs at beginning of note, as necessary.	SIGNATURE — Sign full name and title after entry.
04-15-05		7P	I was called to the [illegible] at about 5:55pm re injury to consumer. On examination a laceration of about 2.5cm on Lt eye lid. Minimal bleeding noted. Area cleansed c NS + DSD applied. To be seen by MD re further care. Await receipt of [illegible]	M Layne RN
4/15/05			9pm [illegible] seen by [illegible] and Dr. [illegible] for [illegible] Lt eye lid & sutures used to close. [illegible] Alert fully conscious and responsive. VS 110/[illegible] P [illegible] R18. Ate well. No vomiting noted. [illegible] No distress noted.	P [illegible] RN
4/15/05		9Pm	Sutures on LT eye lid remain intact. Area swollen. Head injury precaution continued. Remain on W/Chair for unsteady gait. Temp 98 Pulse 78 R18. Fully alert & awake. Ate well. Meds taken well. Head injury precautions continued. Had BM this evening. No distress noted. BP 130/80. Observation continued.	[illegible] RN
04/16-05		7	Sutures to Lt eye lid are intact. No discharge noted although lid is swollen appears red + eye is closed. AM medication administered. Head injury precaution kept. VS checked same BP 110/78 T98.2 P72 R18.	M Layne RN
4/16/05		3p	T98.4 Sutures Lt eye intact no discharge noted. Eye area appears red & swollen. Meals taken well. [illegible] head injury precautions and OOB w/c for unsteady gait.	[illegible]
04/16/05		[illegible]	[illegible] Sutures to (Lt) eye intact. Swelling persists. BP 128/78 P-66. Not in any distress. Kept head injury precautions.	[illegible]

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CLINICAL NURSING NOTES

Full Name of Client: Young, Valerie   Consecutive Number: Living Unit: 3M

YEAR / DATE	HOUR AM	HOUR PM	NURSING OBSERVATION Entries must be legible and written in black ink. Sign full name and title after each entry, record vital signs at beginning of note, as necessary.	SIGNATURE Sign full name and title after entry.
4/17/05		2PM	Lt eyebrow swollen + red seen by Dr Madhavi ordered Augmentin 875mg BID x 5 days 4/17 - 4/22/05. 1st dose given 1300PM. Sutures to Lt eyebrow intact contd observe. —	[illegible]
04/17/05			6pm Sutures (L) eyebrow intact, eyebrow is swollen and red. Started on Augmentin today as per Dr. Madhavi. Not in any distress. Head injury precautions kept. BP — 133/63, P — 68.	[illegible]
		8pm	Fleet enema given — no BM reported this time.	[illegible]
4/18/05	6AM		A/B in progress. No side effects noted such as rash or vomiting. Lt eye brow remains swollen and red. No BM noted.	[illegible]
4/18/05		9PM	Continues to receive A/B Therapy as ordered. Lt eye brow slightly swollen. Sutures remain intact. Diet/meds taken well. No problem noted.	[illegible]
04-19-05	7A		Slept through the night. No complaints offered. AM medication taken. Bodily AB therapy cont'd. Sutures to lt eyelid intact.	[illegible]
04/19/05			6pm (Lt) eye swelling and redness subsiding. A/B in progress. V/S — stable. Sutures (Lt) eye brow intact.	[illegible]
			8pm Had large BM after Fleet enema.	[illegible]
4/20/05		3PM	Vit B complex 1 tab po QD ordered.	[illegible]
04/21/05			4pm P/C Tylenol 650 mg [illegible]. New orders: Tylenol [illegible] Q 4 hrs + [illegible] QUS.	[illegible]
			6pm A/B in progress (Lt) eyebrow sutures intact, redness + swelling subsiding. V/S stable.	[illegible]
04/22/05			6pm Sutures (Lt) eyebrow intact, no swelling, no redness noted. V/S stable.	[illegible]

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Full Name of Client: Young, V.

CLINICAL NURSING NOTES

Consecutive Number:

Living Unit: 4/4

YEAR / DATE	HOUR AM	HOUR PM	NURSING OBSERVATION Entries must be legible and written in black ink. Sign full name and title after each entry, record vital signs at beginning of note, as necessary.	SIGNATURE Sign full name and title after entry.
5/5/05		2P	Consumer Kept RJMC Radiology appt - X-ray of L-S spine	
			done	[illegible]
05/18/05			[illegible]	[illegible]
5/20/05		7P	Consumer has a laceration on the left side	
			of her head. 1½ inches in length and less than	
			½ inch in dept. Small amount of bleeding.	
			Pressure applied and bleeding stopped.	
			Small amount of hair removed from the area.	
			No other area of her head is injured. NO LOC noted	
			Head injury precaution in progress. V/S	
			monitored and stable. BP 130/78 P76 R20.	
			She is alert and oriented to her surrounding.	[illegible]
			Consumer to be seen by MD. Laceration was	
			clean [illegible] N/S and remained open Due to the	
			fact consumer peeled dressing off.	[illegible]
5/20/05		12M	[illegible] Dr Milos laceration [illegible] 4 sutures applied	
			to laceration by Dr Milos. Head injury precaution in progress [illegible]	
			[illegible] BP 116/[illegible] P70 [illegible]	
			[illegible]	[illegible]
05/20/05			5pm alert, not in any distress, head injury	
			precautions kept. BP - 117/74, P-78, R-18	
			Sutures to head intact, Keflex [illegible] 6 hours	
			in progress	V. [illegible]
			9pm BP - 124/80, P - 68, sutures to head intact,	
			head inj precautions kept.	V. [illegible]
5/21/05	12MN		Consumer sitting up in chair. Sutures to head intact.	[illegible]
	6AM		Slept off and on. Keflex 500mg PO in progress. No signs of	
			infection observe. Suture intact. No vomiting noted. BP 130/78 P70 R20 T98.6.	[illegible]

C-25-NS-MED
[illegible]V 10/03

CLINICAL NURSING NOTES

[illegible] Name of Client: Young Valerie Consecutive Number: Living Unit: 324

[illegible]EAR / [illegible]ATE	HOUR AM	HOUR PM	NURSING OBSERVATION Entries must be legible and written in black ink. Sign full name and title after each entry, record vital signs at beginning of note, as necessary.	SIGNATURE Sign full name and title after entry.
04/26/05			7pm Returned from neurology appt. (Dr. Pandya)	
			Pt has mononeuropathy advised splint, PT + OT	
			X/ray (S. spine) EMG in KCH. F/u c M.D.	V. [illegible]
5/2/05			Zyprexa dose is changed as 5mg in AM + 20mg	
		6PM	P.O. HS starting on 5/3/05.	[illegible] RN
05/04/05			3:15pm Reported by staff that pt had LBM x 3	
			T-98.8 (Rectal) P-80 R-20, BP-121/70. Not in any	
			distress. Seen by Dr. [illegible] of 4pm	
			abdomen distended tender [illegible]. [illegible]	
			30cc given stat with good effect. TO	
			↑ fluids P.O. x 24-hours, V/S Q6h x 24 hours	V. [illegible]
			TO I/O	
			6pm - BP - 138/86 P-67 Abdomen mildly	
			distended but very soft, no tenderness noted	
			Meds given. T-98.6 (R)	V. [illegible]
			9pm - BP - 126/78, P 68, abdomen soft, not tender,	V. [illegible]
			slightly distended.	
5/5/05		2P	Consumer kept KJMC Radiology Clinic appt. X-ray of L-5-	
			Spine done. Blood work done in Am	[illegible]
5/7/05	7A		Seen by Dr. Madhav for OP file for abrasion on	
			(L) leg. B/O order x 5 days [illegible].	[illegible]
5/10/05		9PM	Fleet enema given. Had large BM this PM	
5/11/05		6PM	Seen by Podiatrist. Nails debridement done. Placed on	
			Lotrimin cream to apply between toes. D/C on 5/28/05	
			Same was applied. For follow up on 7/13/05.	[illegible] RN
5/16/05			[illegible]	
			[illegible]	[illegible]
05/17/05			9p Fleet enema given, had large soft BM.	V. [illegible]

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REV 10/03

CLINICAL NURSING NOTES

Full Name of Client: Young Valerie   Consecutive Number: Living Unit: 314

YEAR / DATE	HOUR AM	HOUR PM	NURSING OBSERVATION — Entries must be legible and written in black ink. Sign full name and title after each entry. record vital signs at beginning of note, as necessary.	SIGNATURE — Sign full name and title after entry.
5/22/05	7A		Slept well. Sutures intact to left side of forehead.	
			NO distress reported during the night	[illegible]
5/23/05			[illegible] [illegible] [illegible] [illegible] [illegible]	
			BP 115/. Alert, walking about well. No	
			[illegible] of [illegible] [illegible] noted. Obs. —	[illegible]
5/22/05		6PM	Consumer spitted out meds. Refused on second	
			attempt. 9PM meds taken well. Fleet enema	
			I unit given. BM not reported yet. To observe.	[illegible] RN
5/23/05	2P		Refused 7AM meds spit [illegible] MD [illegible] meds	[illegible]
5/23/05	7A		To be seen by MD for (L) foot swollen. Both	
			feet were elevated this AM. NO broken skin	
			noted. To be seen.	[illegible]
5/27/05			Client seen for bilateral edema of feet.	
			No tenderness noted. Continue leg elevation as	
			possible. Obs. —	[illegible]
5/27/05			8PM; meds spitted out. Will try again. Feet	
			Kept elevated while on W/chair. 9PM meds	
			taken well. Remained on W/chair —	[illegible] RN
05/29/05		8:30	pm Fleet enema given with good effect — had	
			large BM.	
5/31/05	3:15		Staff reported that consumer was found lying on floor	
			next to bed. No injuries noted. To be seen by MD	[illegible]
			I/R submitted	[illegible]
5/31/05			9Am seen by MD. No injury noted.	[illegible]
6/14/05			Had X large BM this eve. Meds taken well.	[illegible] RN
06/16/05			8pm [illegible] X-large soft BM today.	[illegible]

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REV 10/03

CLINICAL NUR[illegible]G NOTES

Full Name of Client: Valarie Young. Consecutive Number: Living Unit: 314

YEAR / DATE	HOUR AM	HOUR PM	NURSING OBSERVATION Entries must be legible and written in black ink. Sign full name and title after each entry. record vital signs at beginning of note, as necessary	SIGNATURE Sign full name and title after entry.
6/19/05	8-30	PM	I was called by the staff to come and see Ms Young. She does not look good. On checking did not feel pulse and breathing. Looks very pale. Placed on the floor. CPR was given and start reviving. After a very short time start screeming saying leave me alone. Staff called 911 and Code Blue was activated. DR Madison assisted immediately at 8-30. Oxygen inhalation was given and I/V was started By MD. EMS came at 8-45 and took over. At at 9-30 PM Hospital called and informed that consumer expired. Family was informed by Hospital CASE No was 3154. Medical examiner LABELLA	AJ Jr. RN